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Safety Net System: A Case Study of Primary and Specialty Care for Uninsured Residents in Cobb County, Georgia

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Executive Summary

The purpose of this study is to analyze data from Cobb County safety net facilities to determine primary and specialty care accessibility for low-income patients as evidenced by the availability of resources, affordability of services, accountability of quality care, and policies for the uninsured. The study provides insight for assessing the circumstances in Cobb County and supplies information on services that may need evaluation and expansion. Data for safety net facilities were obtained through interviews with a questionnaire that consisted of 13 dichotomous questions, 10 closed-ended questions and 2 open-ended questions. All the executive administrative staff or chief executive officers from safety net facilities in Cobb County participated in the survey.

First, the accessibility of providers and limited hours of operations compared to the number of uninsured residents in Cobb County is very small. This means an excessive number of patients are forced to visit the emergency room departments, even for minor conditions. Moreover, phone access to a primary care provider is attainable at only one of the community health clinics.

Second, the lack of tracking primary language along with unanimous reports on interpreting needs is a significant finding. The U.S. Census Bureau's American Community Survey estimates that Cobb County has 114,280 persons (age 5 and older) who speak a language other than English. The 2005-2007 American Community Survey also estimates that 22,626 Latinos did not consider themselves Mexican, Puerto Rican or Cuban. Chief executive officers and executive directors report that the second most

common interpretation need is for Portuguese speaking patients. An increase in Central- and Southern American residents may have resulted in this need. Seeing the trend across organizational lines can help Community Health Centers (CHCs), emergency departments, and all healthcare providers plan for the future needs.

Third, the outreach services provided showed that 71 percent of the participants had a Drug and Alcohol Program. Perhaps these programs emerged from federal requirements, and physicians seeing a need, or from an increased diagnosis of disease. Further study on the goals, participation, and outcomes of these programs would be advantageous. Additionally, 86 percent of the participants provided optional spiritual support to their patients. The executive directors expressed the benefit of these varying programs to their patients. In sum, an in-depth analysis of these programs would also be valuable to health leaders and public policy makers.

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Introduction

The coverage and cost of healthcare and the need for reforms has been a growing force in American minds. Since the beginning of President Barack Obama's administration, intergovernmental discussions and media coverage have brought increasing attention to this issue. The American healthcare system has been labeled paradoxical. Some people receive high end or excessive care that can almost be detrimental, while others receive limited or no care due to a lack of insurance or accessibility to a provider. The insurance market has left many people out because it is not accessible or affordable. Many uninsured individuals are left with no or extremely limited access to medical care. Providers get frustrated with the enormous amount of paperwork from both insurance companies as well as the government.

Gaining and increasing access to quality healthcare for the uninsured across the nation and in Cobb County, Georgia can be extremely difficult. The Department of Health and Human Services is the primary agency for protecting the health of all Americans. However, its ability to provide quality healthcare is becoming exponentially difficult as the cost of care increases and number of uninsured persons grows.

Importance of Study

Medical care for the uninsured throughout the United States is largely accomplished by a combination of safety net facilities made up of hospitals and clinics. Lack of primary and preventive medical care causes amplified illness in the community,

higher cost to individuals, and counties paying for emergency room care along with overflowing emergency rooms. Untreated health conditions escalates the severity of the disease, decreases the labor force, families' income, and overall stability of communities.

The purpose of this study is to analyze data from a survey of Cobb County safety net facilities to determine primary and specialty care accessibility for low-income patients as evidenced by the availability of resources, affordability of services, accountability of quality care, and policies for the uninsured.

Literature Review

Access to Healthcare

Access to healthcare has two primary facets. This includes the ability to pay and the availability of accessible personnel and medical facilities. The majority of people get insurance if and when their employers offer it and help pay for the costs. There was a time period in the 1930s to 1970s where the number of uninsured decreased due to Medicare, Medicaid, and private insurance. That number has now been increasing since the mid-1970s.

History of Insurance Development and the American Healthcare System

The first hospital in the United States began in 1751 in Pennsylvania. However, it was not until the late 1800s that the American medical profession really emerged. This was mainly due to increased education for physicians and the development of hospitals. The period from 1845 to 1899 is considered the founding phase of the American Medical Association (AMA, 2009) which took rising control in the medical market.

A growing number of medical and dental schools opened in the 1930s. During the Great Depression, people struggled to pay for basic needs like medical care and housing. While physicians attempted to accommodate people in need, hospitals had fixed costs and rigid structures. As hospitals experienced significant decreases in cash flow, they turned toward insurance as a steady flow of income. Health insurance began to help people prepay for medical costs. Baylor University implemented the first health insurance plan in 1929. “By paying on the fee in advance, 1,500 school-teachers contracted with the hospital to provide care should they need it. The fee was paid whether or not the individual teacher ever used the service” (Wasley, 1993, 11).

Quickly thereafter, groups of hospitals and cities organized multi-hospital insurance plans which gave the individual more choice of providers. This was the starting model for Blue Cross which was established in Sacramento, California in 1932 (Wasley, 1993). Although these plans benefited patients, their goal was really to maintain steady income for the hospitals, which ultimately created more problems.

Blue Cross/Blue Shield became the leading healthcare provider. Seeing a monopoly, the AMA lobbied against a tax exemption created for Blue Cross/Blue Shield. Blue Cross/Blue Shield responded by requesting slightly different tax exemptions, giving them an enormous advantage over other insurance companies. These special credentials allowed them to offer lower costs and aided Blue Cross/Blue Shield to hold 40 percent of the market share until the 1980s (Wasley, 1993). When Blue Cross/Blue Shield developed a new system called cost-plus procedures, horrible consequences broke out. Cost-plus reimbursed doctors and hospitals based on a percentage of their costs plus a percentage of their working and equity capital. This permitted doctors to charge

whatever they wanted without a cap or any accountability. The system was widely adopted by other insurance providers including Medicare. Knowing the limits of this freedom meant increased income, it encouraged a great deal of corruption in hospitals. Similarly, patients were not confronted with procedure costs and did not experience any loss by receiving care. Therefore, families did not abstain from the finest care possible, especially since it was not their funds being spent.

The next major healthcare development occurred in the 1940s with employer provided insurance. World War II created a shortage of labor in America. Since employers could not afford to increase wages, they attracted people with "fringe benefits," using health insurance as one such additional incentive. Simultaneously, the Internal Revenue Service (IRS) ruled that both employers and employee did not have to include health insurance benefits when accounting for their taxable income. Individuals as well as unions soon realized this great bargaining tool and worked it into their contracts.

"By the end of 1954, more than 60 percent of the population had some type of hospital insurance, 50 percent had some type of surgical insurance, and 95 percent medical insurance. In 1945, employers paid only 10 percent of healthcare expenses, but by 1950 collective bargaining agreements were requiring them to pay 37 percent" (Wasley, 1993, 15). The government encouraged provider oriented plans while employers offered first-dollar plans for routine care. This also increased healthcare costs since they went through a third party.

Other insurances like auto and homeowners require people to pay out-of-pocket for regular maintenance but covers a person for disasters. American health insurance

worked the opposite way. First dollar or front end health insurance pays for the expenses of routine care but neglects disastrous events that would cause long-term disabilities or destroy a family completely. Insurance companies competed even more with Blue Cross/Blue Shield by developing cheaper plans to employers with relatively healthy employees. Blue Cross/Blue Shield then lobbied lawmakers to change regulations once again creating the "community rating" system (Wasley, 1993). This allowed insurance companies to calculate premiums based on the number of employees, thus costing the employer more or being in jeopardy of losing insurance altogether if one employee became ill. Thus it was riskier and cost small businesses more, making it extremely difficult for them to afford insurance.

Employer-provided care had now left a large gap for people without insurance, mainly the elderly, the unemployed, and the poor. Public Interest Groups, businesses, and individuals pressured the federal government to provide a system that would help supply care for these groups. Some groups advocated for a national health plan while other groups like the American Medical Association (AMA) pushed for decentralized state programs. The compromise was the birth of Medicare in 1965.

Medicare Part A was a lesser version of those who supported a national health plan and was the largest section of the program. Medicare Part B covered physician services and was paid for by a combination of general funds and premiums. Medicaid was the section for those who had sided with the AMA. It paid medical care for the poor, regardless of age.

This system of third-parties now reigned over the American healthcare industry. The majority of people were covered either by a government program or private

insurance. However, the same problems due to the lack of regulation for cost-plus reimbursements, patient incentives, and first-cost coverage sped up the rising costs of medical costs.

Personal healthcare expenditures per capita increased from $82 in 1950 to $7,421 per person in 2007. Medicare spending jumped from $25.2 billion to $431 billion from 1978 to 2008 (U.S. Department of Health and Human Services, 2009). When employees' wages went up in the 1970s so did their tax bracket which augmented the desire for employer-provided nontaxable benefits. Unfortunately, the governmental response was to control medical prices through more restrictions to hospitals, providers, and even patients. Health Maintenance Organizations (HMO) were created in 1973 as part of this solution.

The first HMO restriction required all companies with twenty-five or less employees to offer this plan, which has continued to increase by millions of people each year. Another factor for Medicare expenditures was the Social Security segment which had hospital reimbursements on a "prospective payment system" (PPS). Fixed fee schedules were set for specific sets of certain diagnosis, allowing Medicare to keep or lose any difference. The hope was to encourage hospital competition. "In the five years following the introduction of PPS, the average annual rates of growth in Medicare spending were 6.5 percent for the Hospital Insurance Program and 13.8 percent for the Supplemental Medical Insurance Program, much higher than the overall rate of inflation" (Wasley, 1993, 16). More pressure was put on states by lobbyists and interest groups to mandate laws regarding benefits for certain diseases covered under insurance. The number of these laws has multiplied significantly and is another part of the cause for

increased insurance costs. All these things have fostered a snowball system that continues to elevate insurance costs for Americans.

In addition to health insurance, the United States has had a great deal of economic change. It has gone from a manufacturing based labor force to a service based labor force. From March of 1973 to March of 2007, "workers in the service sectors went from 70 percent to 83 percent" (Lee and Mather, 2008, 7). The instability of employment and employer based coverage created more holes and more uninsured people.

Present Day

Diane Rowland, executive vice president of the Kaiser Family Foundation, pointed out the decreases in the percentage of people with employer-provided insurance since 2000. She noted that the increase of small businesses, which typically cannot afford to offer insurance because of costs, could lead to a bigger decrease in private insurance even if the economy improves (The Associated Press, 2009). Questions of accountability have risen about the frequency of usage and effectiveness of insurance when needed. The American College of Physicians stated on its website that compared with the insured, the uninsured are less likely to have a primary medical home or regular source of care and are more likely to delay their care.

Insurance Limitations and Gaps

Even those that are insured are not guaranteed access to care. Many insurance plans have restrictions, especially to specialty care and referral services. People with low-income may have minor financial changes which could disqualify them for Medicaid.

For people with moderate income even co-pays can be a significant financial bill and can create financial deficits. This could result from either chronic illness or a catastrophic event. “Illness or medical bills contributed to 62.1% of all bankruptcies in 2007. Unaffordable medical bills and income shortfalls due to illness were common; 57.1% of the entire sample (92% of the medically bankrupt) had high medical bills, proportions that did not vary by insurance status ” (Himmelstein et al., 2007, 3). Long-term care is another problem since this is often an insurance restriction, especially for the elderly or chronically ill.

Disparities in Healthcare

Thanks to more preventive medicine and advances in medical technology, life expectancy has increased for most Americans. However, good health is harder to attain for some ethnic and racial minorities in America, because healthcare is correlated with economic status, race, and gender (U.S. Department of Health and Human Services, 2003). More attention has been given to this recently as legislators, and healthcare professionals determine how to eliminate or reduce such disparities.

Women have been a significant part of these studies since past research has shown that more women leave physicians because they are unsatisfied with care. Perhaps this is due to bedside manner, a lack of cultural sensitivity, or even provider training. Physicians are also less likely to counsel women about cardiac prevention, disease, and risk factors (American Heart Association, 2009). Compared to men, women can present very different risk factors such as fatigue or stress when it comes to heart disease. Presenting risk factors may be assessed as contributors of stress levels or menstrual life

cycles instead of more serious problems. Limited providers and dissatisfaction with care leaves a bigger divergence in preventive and primary care services.

Because more populations of minorities are uninsured compared to Caucasians, physician access is more difficult for these groups. In Georgia, the statistics provided on Table 1 to Table 4 help to show the magnitude of the problem.

Table 1. Distribution of the Nonelderly Uninsured by Age, Georgia (2006-2007), U.S. (2007)

	GA	GA	US	US
Age Group	**#**	**%**	**#**	**%**
Children 18 and Under	326,060	19.80%	8,872,090	19.70%
Adults 19-64	1,317,970	80.20%	36,098,690	80.30%
Total	1,644,030	100.00%	44,970,780	100.00%

Table 2. Distribution of the Nonelderly Uninsured by Family Work Status, Georgia (2006-2007), U.S.

	GA	GA	US	US
Work Status	**#**	**%**	**#**	**%**
At Least 1 Full Time Worker	1,148,000	69.80%	31,079,220	69.10%
Part Time Workers	171,530	10.40%	5,478,690	12.20%
Non Workers	324,510	19.70%	8,412,870	18.70%
Total	1,644,030	100.00%	44,970,780	100.00%

Table 3. Distribution of the Nonelderly Uninsured by Gender, Georgia (2006-2007), US (2007)

	GA	GA	US	US
Gender	#	%	#	%
Female	760,290	46.20%	20,723,740	46.10%
Male	883,740	53.80%	24,247,040	53.90%
Total	1,644,030	100.00%	44,970,780	100.00%

Table 4. Distribution of the Nonelderly Uninsured by Race/Ethnicity, Georgia (2006-2007), U.S. (2007)

	GA	GA	US	US
Race	#	%	#	%
White	607,850	37.00%	20,264,170	45.10%
Black	599,140	36.40%	6,941,040	15.40%
Hispanic	375,300	22.80%	14,558,420	32.40%
Other	61,740	3.80%	3,207,150	71.30%

Notes: Percentages may not sum to 100% due to rounding effects. For more details, see "Notes to Demographic and Health Coverage Topics Based on the Current Population Survey (CPS)" at http://www.statehealthfacts.kff.org/methodology

Sources: Tables 1-4 come from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

Due to programs under Medicare and Medicaid, the 19-64 year old population is the largest age group without care in Georgia and the United States, and 80.3 percent of that population is working. This means that individuals who are attempting to accomplish their personal and familial needs are still unable to achieve mainstream adequate medical care.

Hospitals

Before there was an official "safety net," hospitals were built in the United States primarily for the poor through the support of religious organizations or affluent patrons. The altruistic hospital model changed more from charitable organizations to businesses in the late nineteenth century. It was then that hospitals started taking in patients from all socioeconomic ranks. With the Internet boom and increased medical technology, more hospitals developed relationships with medicals schools and became teaching hospitals. The businesses model began to rely more and more on patient revenue.

> In 1922 patient care revenue accounted for 65.2 percent on average of the total revenue of general hospitals. In 1994, after the growth of private insurance and introduction of Medicare and Medicaid, 94 percent of hospital revenue on average was derived from services to patients (Wasley, 1993, 15).

Payments from private insurance added to revenues or compensated for the poor who were underpaying. Hospitals diversified their revenue streams even more with federal funding. The largest portion were funds from Medicare and Medicaid programs but also included homeless, migrant workers, and those with HIV/AIDS.

Safety Net or Disproportionate Hospitals

The health-care safety net encompasses a range of organizations that aim to provide healthcare to underserved populations, including individuals who are uninsured and low-income. It is chiefly comprised of public hospitals, private not-for-profit hospitals, federal, state and locally-supported Community Health Centers (CHCs), and local health departments. These providers serve an unbalanced portion of the low-income uninsured, underinsured, and a substantial proportion of Medicaid beneficiaries who comprise the "population in need" of a healthcare safety net network (Forrest and

Whelan, 2000). Many of these individuals are minorities, immigrants or undocumented, and live in communities with economic disparities.

These hospitals often exist as the sole source of hospital and specialty care for the populations they serve. Furthermore, they are often the only source of outpatient services for their communities. In particular, emergency rooms often serve as sources of specialty care for individuals who do not have insurance, and cannot afford private care or do not receive care in a CHC. "However, the largely voluntary nature of the hospital safety net means that it is affected by the ebbs and flows of markets and public policies because these inevitably influence the resources providers have available to support indigent care" (Bazzoli et al., 2005, 1047).

Under the 1986 Emergency Medical Treatment and Labor Act (EMTALA), hospitals that participate in Medicare must furnish screening and necessary stabilization services to everyone who enters the hospitals' emergency department (U.S. Department of Health and Human Services, 2009). However, the law does not require emergency departments to provide care for those who do not have an emergency diagnosis. Emergency conditions are defined as currently threatening a person's life or long-term health. "Under the new (2008) policy at several large metro Atlanta hospitals, emergency room patients who are screened and found not in need of immediate medical care will be denied treatment unless they pay a deposit or co-payment on insurance. Those unable to pay are directed elsewhere to get the care they need. And too often, there is no 'elsewhere' in Georgia" (King, 2008, E6). Even in major metropolitan areas such as Atlanta, with more than three dozen government-subsidized clinics and health centers, patients flood Grady Memorial Hospital and Wellstar Kennestone emergency rooms for

treatment of minor illnesses or chronic conditions. This is partially because many of the local clinics that might otherwise take such patients have limited weekday hours.

These hospitals still receive supplemental funds from state government in addition to the reimbursement they normally receive from under the Medicaid Program. They may also receive funds from local or private grants and private donors. This system is in grave danger. The federal government has been seeking larger cutbacks to meet budget requirements. Secondly, payments are based on a fee-for-service systems and inpatient use of hospital services. Managed care uses different payment methods by attempting to reduce hospital use, and moves care to lower-cost and ambulatory settings. This system distorts the methodologies for accounting and ensuring these hospital payments.

Additionally, many primary-care physicians in private practice do not accept Medicaid or PeachCare patients. Some hospitals appear to not open urgent-care centers for fear of disaffecting the primary-care physicians they rely on for new admissions. The best case scenario would be a coordinated, easily accessible network of primary-care services which would be pulling patients away from hospital emergency rooms.

Community Health Centers

Community Health Centers (CHCs) have become an essential component of healthcare access for the medically uninsured. Patients who are uninsured typically pay according to a sliding scale based on their family income compared to the federal poverty level although some clinics may be free or have standard procedure costs. These centers were much rarer just forty years ago. A few committed civil rights and health activists working in inner-city neighborhoods, and rural areas first saw the urgent need for

healthcare in the 1960s. One such leader, H. Jack Geiger, was a physician who saw how, after Apartheid, the new health model brought astounding health results to the Zhulu population in South Africa (Witte, 2009). Geiger's studies yielded experiential leadership to urge changes in the United States. President Lyndon Johnson, also proclaimed the "War on Poverty" in the 1960s and healthcare became one of the vanguard topics among the American people. It was then that such clinics first began in 1965 as part of the Office of Economic Opportunity (OEO) to provide entry points for the poor and underserved. The model encouraged local communities to collaborate with federal funding to fight poverty. Health centers deliver a range of services including preventive, diagnostic, and laboratory services, dental care, case management, mental health, and health education. They also often provide comprehensive medical or "wrap-around" services (e.g., language interpretation, transportation, outreach, nutrition, and social support services) that target vulnerable populations. Language and outreach programs are attempts to help diminish the gaps in ethnic and racial disparities. Many clinics are often the only source of medical or dental care that families or individuals visit. Some clinics have expanded to offer mental health services including family counseling, and substance abuse treatment.

The health centers program joined with the migrant health program, and was moved to the Department of Health, Education and Welfare in the 1970s which is now known as the Department of Health and Human Services (DHHS). Congress permitted primary healthcare programs for homeless centers or public housing residents in 1975 (Taylor, 2004).

These centers became the first Federal Health Qualified Health Clinics (FQHCs). FQHCs are eligible to apply for grants, and receive certain funds if they meet specific criteria. These criteria include:

- Located in a medically underserved area (MUA) or serve a federally designated medically underserved population (MUP),
- Have tax exempt, public, or nonprofit status,
- Provide comprehensive primary medical care and other referral services as needed,
- Have a governing board whose members are patients of the health center, and
- Provide services to everyone in the target area regardless of ability to pay, this includes having a sliding fee plan based on family income

(Taylor, 2004, 2).

Specifically, the condition that at least fifty percent of the board of directors must be patients is a distinctive feature. This requirement was meant to keep the centers focused on community needs and inhibits them from becoming part of larger businesses or hospitals.

Sustainability

Health centers rely on multiple revenue sources that include Medicaid, Medicare, federal grants, contributions from philanthropic organizations, third party sources, and patient fees. FQHCs are divided into several categories to receive grants. Centers can tailor their requests for funds as community, migrant, homeless, public housing and sometimes schools. This type of federal funding is intended to be for direct services and limits requests for capital funds. From 1978-1996, HRS prioritized funds for land

acquisition, construction, and renovation. The federal reimbursement policy under the Medicaid Program became a bigger source of funding to centers in the late 1980s. This program developed "preferential payment policy for health centers by requiring "cost-based" reimbursement for both Medicaid and Medicare" (Taylor, 2004, 6). Centers can now meet all the requirements to become a FQHC, called 'look alikes' because they operate like a FQHC but do not receive federal funds, nor are they allowed to be outpatient facilities run by tribal organizations. A Rural Health Clinic (RHC) is another type of center that receives reimbursement from Medicare and Medicaid. A RHC is managed by physician assistant or nurse practitioners where the surrounding community has limited access to primary care physicians. RHCs primarily serve patients that have Medicare or private insurance, although some include Medicaid and uninsured.

In 1996, Congress restricted construction from funding initiatives but allowed minor renovations and equipment purchases (Taylor, 2004). While federal funding for qualified community health centers has increased, some Community Health Centers (CHCs) still complain that much of this money has been devoted to building new health centers in additional communities rather than operating support for existing CHCs that cannot keep pace with patient growth.

CHCs are often understaffed and have limited resources for providing medication, specialized, and long-term care. The combination of significant growth in patient numbers along with dwindling operating budgets has placed a heavy strain on community health centers.

> CHCs, which now number 1,200 nationally, operate in some 6,000 urban and rural sites in every state and territory (many have facilities in multiple locations) and will serve an estimated 16.3 million people this year. About 40% of these patients are uninsured, 35% are covered through Medicaid, and the remainder are Medicare beneficiaries or have private insurance (Iglehart, 2008, 1322).

Quality Health Standards

Health centers also characterize their patients in higher risk nature as well as diminished anticipated health literacy. CHCs are often recognized for achieving significantly higher levels of preventive healthcare for such patient populations in key areas. According to the General Accounting Office, CHCs have also been recognized for exceeding national standards of treatment for chronic conditions. This includes screening, diagnosing, and managing such conditions as diabetes, cardiovascular disease, hypertension, asthma, depression, and cancers. "Uninsured CHC patients were more likely than similar patients nationally to report a generalist physician visit in the past year, having a regular source of care, receiving a mammogram in the past 2 years, and receiving counseling on exercise" (Shi and Stevens, 2007, 159). These populations can make great gains from increased access to preventive medical care because of their greater health needs and the potential system-wide cost-savings that preventive care can generate.

Economic Impact

"Medical care at health centers is around $250 less than the average annual expenditure for an office-based medical provider" (Witte, 2009). Economic studies demonstrate that appropriately targeted preventive services provided at greater levels can

yield large benefits by offsetting future healthcare costs and reducing advances in the severity of diseases as well as mortality. Hence, economists have promoted generous funding for preventive healthcare, particularly in government programs serving at-risk populations (Dor et al., 2008). As a result of improved access to preventive and primary care, health centers are capable of generating a significant return on investment (ROI) in the form of cost-savings and economic benefits to the health system. Health centers also employ healthcare and administrative full-time positions, often including local residents. This aids neighborhood stability, stimulates businesses and helps economic growth.

Challenges

Health centers serve America's most vulnerable populations who are isolated from other forms of care due to geography, language, complexity of health issues, lack of insurance and citizenship. The patient population is usually either in a rural area or economically depressed inner city. Community health clinic patients are also more likely to be uninsured and rely on government programs such as Medicaid. Patients generally qualify as low-income and are primarily female and relatively young. "In 2003, 69 percent of health center patients lived at or below 100 percent of the federal poverty level and 90 percent lived at or below 200 percent of the federal poverty level" (Taylor, 2004, 8). Issues such as transportation, bus routes, gas prices, and reading level of health education materials are daily factors that must be considered in providing care.

Moreover, health centers have limitations in accessing necessary medications for patients after a diagnosis is made. "About one-third of health centers have a licensed pharmacy staffed by a pharmacist either in-house or through a contractual arrangement

with a local pharmacy. Sixty percent of health centers rely solely on their physicians to dispense prescription drugs" (Taylor, 2004, 9). The Patient Assistance Program is a national program that encourages brand name pharmaceutical companies to give a percentage of medications away for free every month. They do this by dispensing certain medications to health centers for qualifying patients. While this helps make these prescriptions more affordable for their patients, individuals must submit an immense amount of detailed financial documentation and paperwork for every medication and participating company. Health centers use these programs to reduce cost for patients but also find a high administrative cost to run such programs.

Community Health Centers (CHCs) overcome many of these barriers by building proximity to their target populations. This means opening clinics in great areas of need defined by the surrounding population's poverty level, infant mortality, and lack of physicians. CHCs are open to all residents regardless of their abilities to pay, citizenship, or insurance status. Centers may even tailor services offered to best fit their local communities' needs.

Organizations also respond to financial pressure in various ways, reflecting differences in core mission in regards to serving low-income and uninsured patients. Clinics supported by government and those qualifying for federal grants for the uninsured have a particular mission to maintain an open-door policy, serving everyone, regardless of ability to pay. Facilities which rely on revenue from inpatient services may behave differently than community-based facilities. Perhaps they have stricter no-show policies or fines for missing appointments. Facilities that do not make enabling services a formal part of a staff member's job may raise questions about the quality of services provided.

"For instance, an average of more than 1 in 3 patients at the surveyed sites did not speak English, yet fewer than half of the sites employed physicians or trained medical interpreters as the predominant means of communicating with non-English-speaking patients" (Weiss et al., 2001, 1245). Relying on volunteers or family members for interpretation can lead to poor communication that compromises the quality of patient education and confidentiality.

Community Health Centers in Georgia

Georgia has a growing network of community health clinics that are seeking to help alleviate the growing problem of uninsured people in the state. The Georgia Free Clinic Network connects non-profit medical and dental clinics across Georgia and served 175,000 of the 1.7 million uninsured in Georgia in 2008 (Georgia Free Clinic Network, 2009). According to the Georgia State Auditor, these clinics are still only reaching 10 percent of the state's uninsured population. Not only are the clinics affording tremendous saving to hospitals and taxpayers, they also provide a primary care base and a place where patients can return for routine care. Clinics who are registered as members of the network report that 80 percent of their patients have one or more chronic illnesses requiring extensive and ongoing medical care, coordination, and health education.

Many of the same disparities seen across the Unites States are also seen in Georgia. Of the patients seen in Georgia clinics, 57 percent are female. Additionally, an average percentage of patients seen at Georgian clinics are: White—40 percent; African American—41 percent; Latino—16 percent. Some of the clinics offer enabling services which include transportation and interpreting services through staff and volunteers.

Clinics rely heavily on volunteers to augment their staff and services provided. In 2006, Georgia Free Clinics reported an average of 2000 volunteer hours per clinic (Darrell, 2006).

Clinics vary in their range of operational hours and services. Most of the clinics are only open part-time, with an average of 9.5 hours per week. The housing market crash and economic downturn beginning in 2007 has meant more job loss which ultimately means both deficiencies in insurance and income. Even with increasing numbers of clinics in underserved areas, many of Georgia's 1.7 million uninsured are still unreached. "Clinics are experiencing increases of 25 to 75 percent over 2008. Despite the growth of patients served, Clinics are forced to turn away an estimated 50,000 Georgians due to lack of capacity" (Darrell, 2006). The time to support the safety net system is greater than ever before.

Methodology

This descriptive case study is a qualitative research design that uses documents, interviews, and follow-up questions where appropriate. Between August of 2009 and December of 2009, the researcher administered surveys to executive directors, chief executive officers, and administrative staff of safety net care facilities in Cobb County that are sponsored by hospitals, community health centers, or public agencies. The unit of analysis used is Cobb County safety net facilities where primary care is delivered. Organizations are classified by whether they were sponsored by the County, a nonprofit voluntary hospital/clinic, an FQHC (whether or not they received federal Section 330 grants), or other non-hospital-sponsored freestanding community health centers. These

facilities typically serve low-income populations. Private physicians' offices and clinics that provide only a narrow range of services (e.g., immunizations) are excluded from the analysis conducted for this study.

Resources

The resources necessary to carry out the project are cooperation from key informants and stakeholders who manage programs at safety net hospitals and clinics in Cobb County. In addition, information from websites such as Online Analytical Statistical Information System (OASIS) and Statehealthfacts.org were used to explain demographics and conditions of uninsured patients. The OASIS is a new system with tools designed to easily access Georgia Department of Human Resources, Division of Public Health's standardized health data repository. It provides standardized health data by county on emergency room visits, hospital discharge, and population data.

These data were cross referenced with data from state health facts, a website project of the Henry J. Kaiser Family Foundation. Kaiser provides free, up-to-date, and easy-to-use health data on all 50 states through the website. Information necessary to carry out the project included data records of number of persons without insurance, disease status reports and demonstrated access to care.

Selection and Sampling

To create a sampling frame of eligible primary care facilities, the researcher contacted all hospitals and community health centers licensed by the State of Georgia that operate sites and provide visits for the uninsured in Cobb County. A total of seven

agencies were invited to participate in the study. Of these, all of them became study participants. It is important to note that the researcher had previous working relationships with six of the participants prior to the beginning of the study.

All three Cobb County hospitals participated in the study. They are Wellstar Kennestone Hospital emergency room, Cobb Hospital and Medical Center emergency room, and Emory Adventist emergency room. Of these, Wellstar Cobb Hospital is dominantly named as a "safety net" hospital, since it accepts a disproportionate number of uninsured patients through its emergency room. There were three nonprofit clinics that participated in the study. Of these, two are only open part-time (less than 20 hours a week). Cobb Health Partners is a clinic managed under the 501 (c)3 of MUST Ministries, a homeless shelter in Cobb County. MUST overseas the clinic staff, financial accountability and health outcomes. The Cobb and Douglas Public Health Department operates out of several physical locations, but only the Cobb County location that provides primary care is included in the study. The Good Samaritan Health Center of Cobb is the only full-time, primary and preventive care agency for the uninsured in this group.

The researcher attempted to collect data through interviews from all eligible sites. Extensive follow-up was conducted; including reminder calls 2 to 3 weeks after the initial survey request, followed by regular telephone follow-up, and e-mail of questionnaires when needed. Data were collected by telephone for selected missing items.

Method of Analysis

The questionnaire includes a broad range of items about institutional policies and practices, patient population, and visit volume. Questions about visit volume and specific policies or practices refer to the 2008 calendar year. A battery of questions is designed about uninsured patient registration policies, whether uninsured are accepted, sliding fee schedules, and fee collection policies (see the Appendices section).

Organizations were also asked whether they provided selected "wrap-around" services (foreign language interpretation, Medicaid eligibility planning, case management, transportation assistance, outreach services, and child care services) and, if so, whether the services are formally staffed or provided informally by volunteers. Questions are included about the degree to which sites have managed care contracts and serve managed care patients, and a battery of questions addresses practices that are typically preferred or required by managed care organizations to provide certain services (e.g., physician admission privilege, automated data systems, evening and weekend hours, and after-hours physician coverage). Questions characterizing each site's patient population focuses on the qualifying income level for the patient or patient's family, percentage of patients who are unemployed, patients who did not speak English, and the range of preferred languages. In addition, visit volume by payer and managed care enrollment were used to characterize each facility's patient mix.

Study Limitations

This case study focuses on a small number of organizations. However, 100 percent participation means the study is in alignment with the scope of the research. As a result of this small group and their diverse operational characteristics, the interview data have limited external validity. The researcher also noted two areas of study that would be beneficial for future research. First, is the number of physicians in Cobb County who accept Medicare and Medicaid. Second, is a study on the amount and types of non-emergency care provided in the three participating emergency departments.

Findings

This section presents the study findings based on the in-person interviews and data obtained through follow-up conversations. The overall findings are in support of previously conducted research. The safety net care system in Cobb County is an informal network of facilities and individuals that seem desperate to accomplish their own mission in part to aid the care of the uninsured. Some of the facilities interviewed shared both formal and informal partnerships that had been established with other participants in the study. These relationships primarily emerged through personal outreach from one chief executive officer to another.

Interview Summaries

Interview with Wellstar Cobb Hospital, Emergency Department: This interview was held on September 2, 2009 at 10 a.m. The meeting was approximately 20 minutes and all questions were answered in person. The respondent brought necessary documents

in preparation for the meeting in order to answer the questions accurately and swiftly. Wellstar Cobb Hospital primarily serves the west and south regions of Cobb County.

Interview with Wellstar Kennestone Hospital, Emergency Department: This interview was held on September 15, 2009 at 9:30 a.m. The meeting was approximately 25 minutes. This organization is the only facility commissioned to accept a disproportionate number of uninsured patients through their emergency room.

Interview with Emory Adventist Hospital, Emergency Department:
The third interview was held on September 17, 2009 at 3 p.m. The meeting was approximately 30 minutes.

Interview with Cobb and Douglas Public Health Department: Due to time restrictions verbalized by the respondent at this facility, the survey was e-mailed on September 3 and returned via e-mail on September 22, 2009. All questions were answered on the returned e-mail. This facility has the unique standing of being the only government run clinic.

Interview with Good Samaritan Health Center of Cobb: The interview was held on August 31, 2009 at 7:30 a.m. The meeting was approximately 20 minutes, and all questions were answered in person. This safety net care facility opened in 2006, and has been operating full-time with primary care medical and dental staff. Affectionately known as Good Sam Cobb, the respondent reported that chronic disease, specifically diabetes and cardiovascular disease, are the most commonly treated diagnosis at the center.

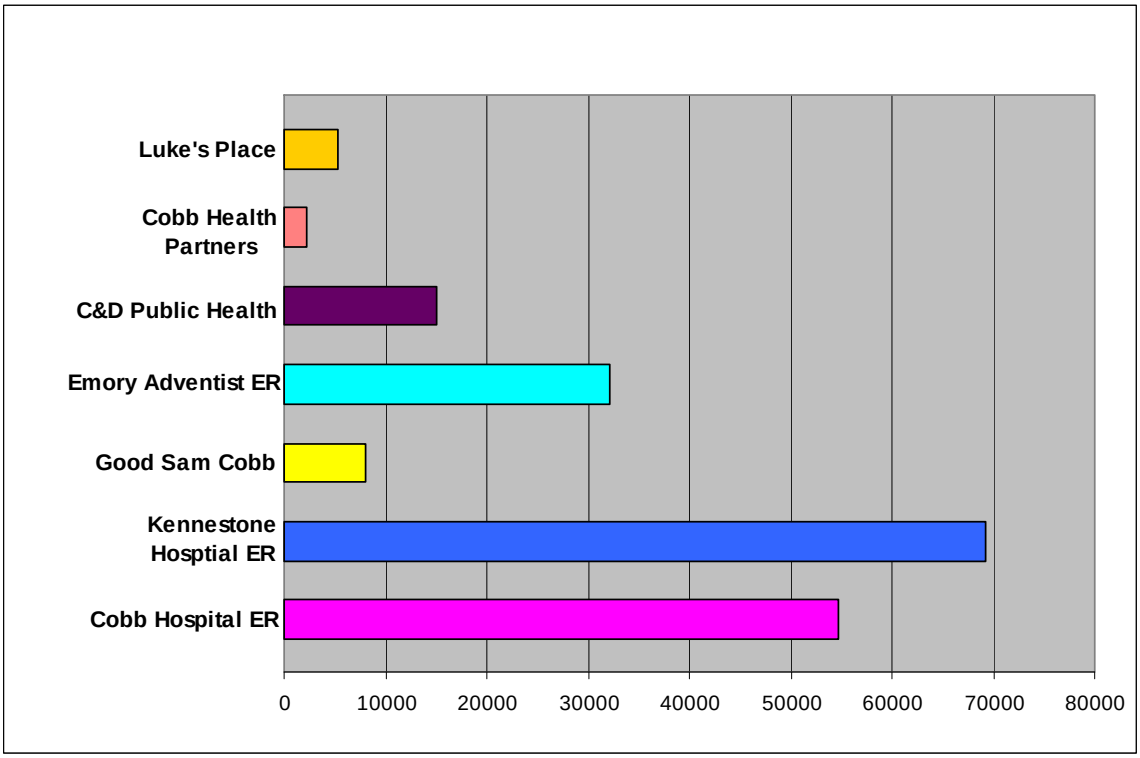
Interview with Luke's Place: The interview was held on September 10, 2009 at 12:15 p.m. The meeting was approximately 25 minutes and all questions were answered

in person. This facility is open on a very limited basis and provides minimal care for people on the community. Volunteer physicians, nurse practitioners, and other health professionals see patients and provide prescription medication only when it has been donated and is available.

Interview with Cobb Health Partners: The interview was held on September 21, 2009 at 3 p.m. The meeting was approximately 30 minutes and all questions were answered in person. Experiencing a rapid increase in patient need, Cobb Health Partners is in a transition stage as it is planning to triple the size and patient capacity of its clinic within the next 12 months.

The U.S. Census Bureau's latest study at the county-level reports that Cobb County had 128,102 uninsured residents from age 0 through 64 in 2006. Due to recent economic conditions and job loss, this number is projected to be even higher in 2008 and 2009. The safety net healthcare organizations that provided patient visits in Cobb County are presented in Graph 1.

Graph 1. 2007 Patient Visits



The graph demonstrates the exceptionally large proportion of uninsured patients seen in the three emergency rooms. To help uncover the patient access process, interview questions were designed to cover descriptive material about patient requirements, policies and general operations of the primary care safety net organizations. The questionnaire consisted of twelve dichotomous questions which are summarized in Table 1 below.

Table 1. Descriptions of Safety-Net Organizations in Cobb County, Georgia

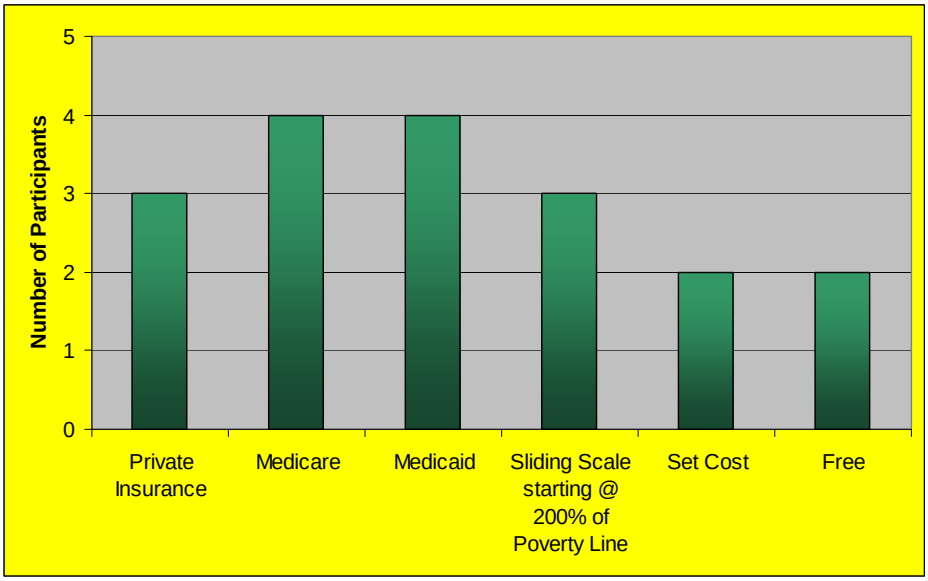
	Dichotomous Questions	Cobb Hospital Emergency Room	Kennestone Hospital Emergency Room	Good Samaritan Health Center of Cobb	Emory-Adventist Emergency Room	Cobb Public Health Department	Cobb Health Partners	Luke's Place
1	Do you have income level restrictions for the patients you see?	no	no	yes	No	no	yes	Yes
2	Do you accept uninsured patients?	yes	yes	yes	Yes	yes	yes	Yes
3	Do patients pay a sliding scale fee?	no	no	yes	No	no	no	No
4	Do you provide translation services?	yes	no	yes	No	no	no	No
5	Are translation services provided by staff?	yes	no	yes	No	no	no	No
6	Do you accept Medicare?	yes	yes	no	Yes	yes	no	No
7	Do you accept Medicaid?	yes	yes	no	Yes	yes	no	No
8	Do you have a Medicaid eligibility plan?	yes	yes	no	Yes	no	no	No
9	Do you have a case manager?	yes	yes	no	Yes	no	no	No
10	Do you provide specialty referral services?	yes	yes	yes	Yes	no	no	No
11	Do you provide transportation services to your clinic or referrals?	no	no	no	No	no	no	No
12	Do you have automated data systems?	yes	yes	yes	Yes	yes	no	No

Affordability of Services

If a safety net organization is open, the cost of care may still be a factor for patients to make an appointment. The ranges of affordability of services are vastly different between the research participants. Cobb Health Partners does not charge anything to their homeless patients. Good Samaritan Health Center of Cobb starts at $15 for an office visit, and then adds fees for services, while Emory Adventist Emergency

Room reports account balances for certain patients that range from $5 to over $40,000. The types of payment accepted by the participating facilities are shown in Graph 2.

Graph 2. Payment Types



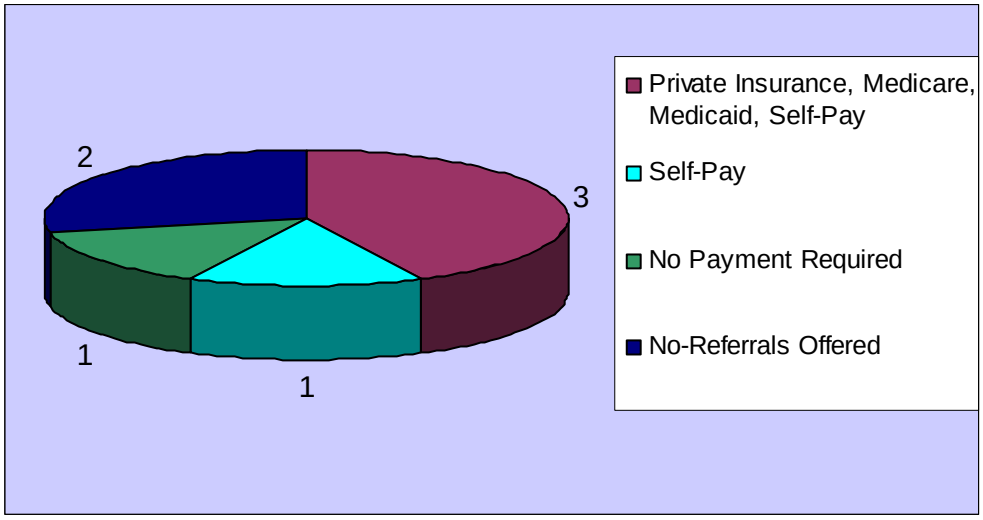
The three emergency departments at Cobb Hospital, Wellstar Hospital, and Emory Adventist Hospital all accept private insurance, Medicare, and Medicaid. Only one organization, Cobb Health Partners did not accept any payment. The respondent reported that this policy is due to their onsite location at a homeless shelter, and 100 percent of their clients are homeless.

Fee Collection Policies for Specialty Care

The seven participating organizations ranged in their patient intake requirements from having no restrictions on patient income levels, requiring patients to have a family income level of less than 200 percent, to not accepting any payment. Healthcare organizations accept payments for specialty services on a variety of policies from private insurance, Medicare, Medicaid, self-pay, no pay, and sliding fee scales. The organizations

demonstrated some overlap in their fee collection policies for specialty care as shown in Graph 3.

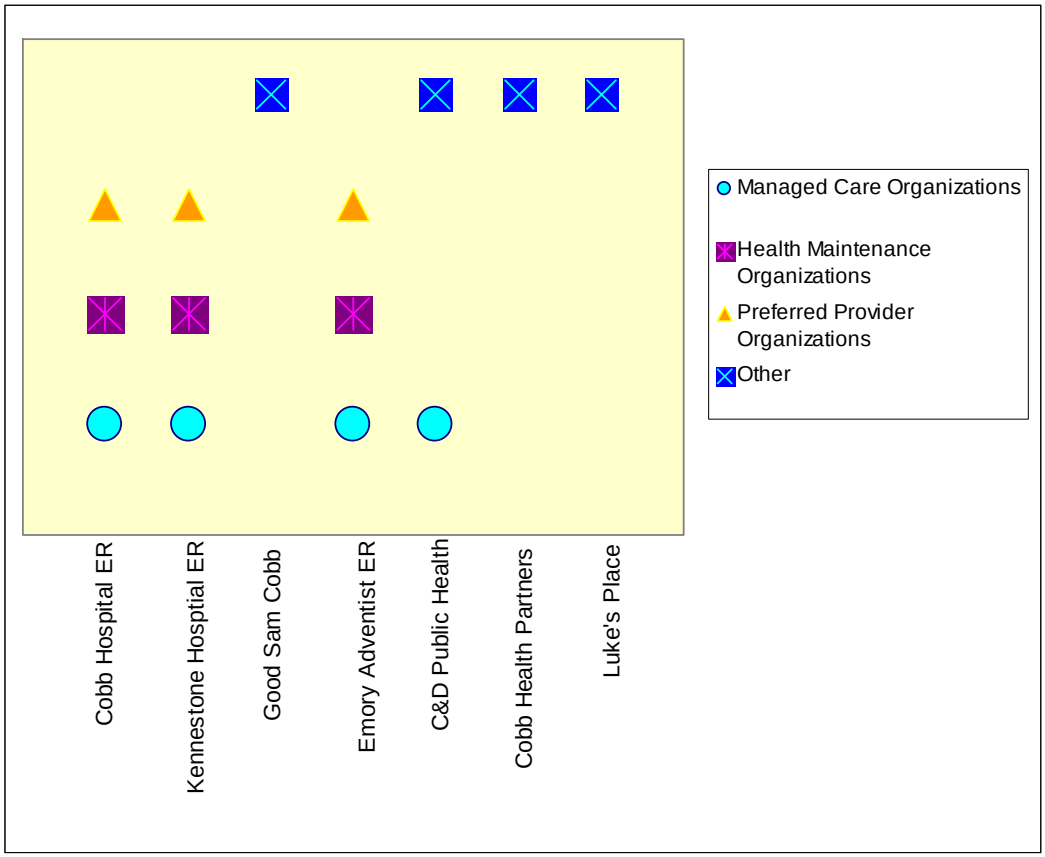
Graph 3. Fee Collection Policies for Specialty Care



Managed Contracts

The question regarding managed care contracts was to gain knowledge on patient accessibility to care. Unfortunately, data on the number of Medicare and Medicaid patient visits was not provided by Cobb Hospital Emergency Department, Kennestone Hospital Emergency Department, or Emory Adventist Emergency Room Department. However, the types of managed care contracts for the participants are shown in Graph 4.

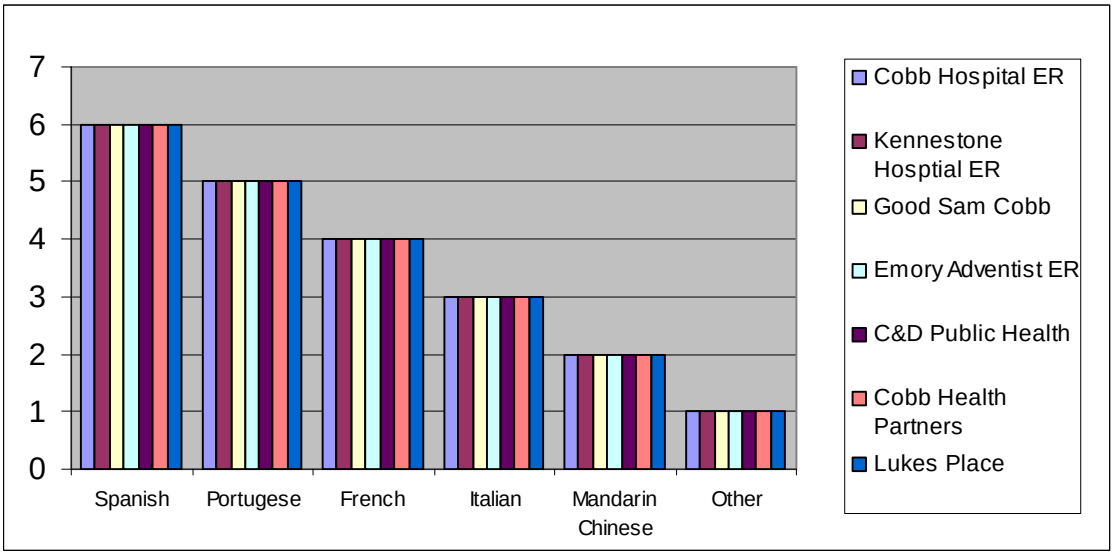
Graph 4. Managed Care Contracts



Wrap-Around Services

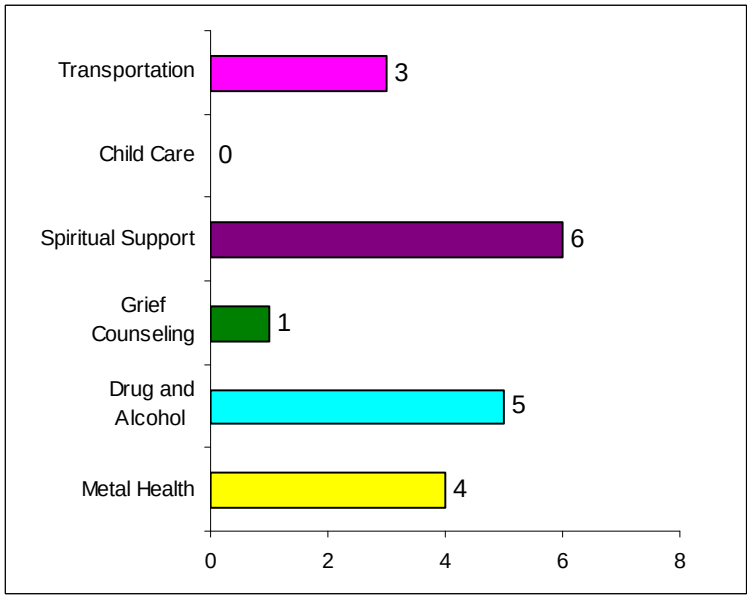
Question number six of the interview asked participants about their need for interpreting services. None of the participants admitted to tracking "language" as one of the collected demographics on their patients. However, all the participants expressed a need for more interpreters. The Good Samaritan Health Center of Cobb is the only organization that had paid staff on its payroll whose job duties included interpreting in Spanish, Portuguese, French, and Italian. Participants were asked to rank the need for interpreting services in six languages. The results are presented in Graph 5.

Graph 5. Interpretation Needs



Outreach services such as counseling, spiritual support, and transportation are included in wrap-around services or specialty care. Graph 6 demonstrates the number of participants with the specialty programs listed. Five organizations provide drug and alcohol support: Cobb Hospital ER, Kennestone Hospital ER, Emory Adventist ER, Cobb and Douglas Public Health, and Cobb Health Partners.

Graph 6. Outreach Services

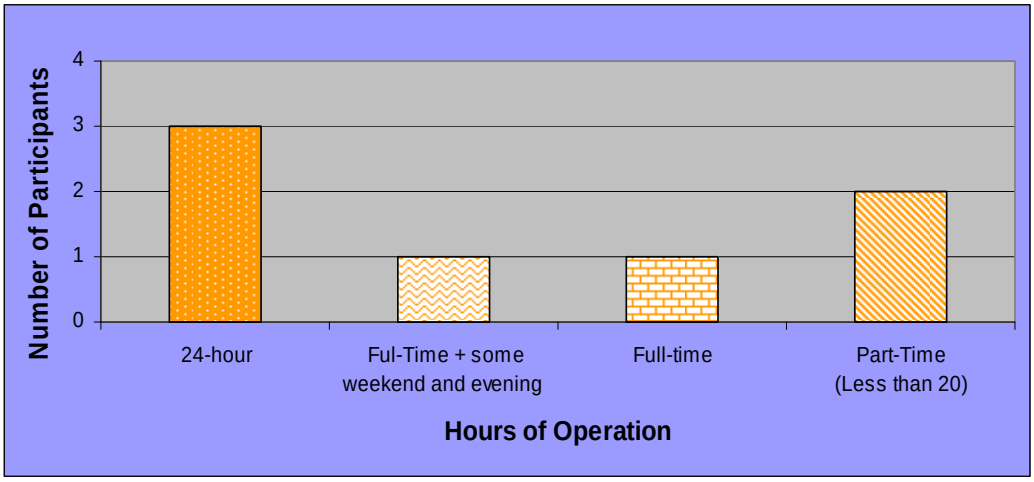


Even more significant may be that six of the seven organization provided spiritual support. Cobb and Douglas Public Health is the only organization that does not.

Availability of Resources

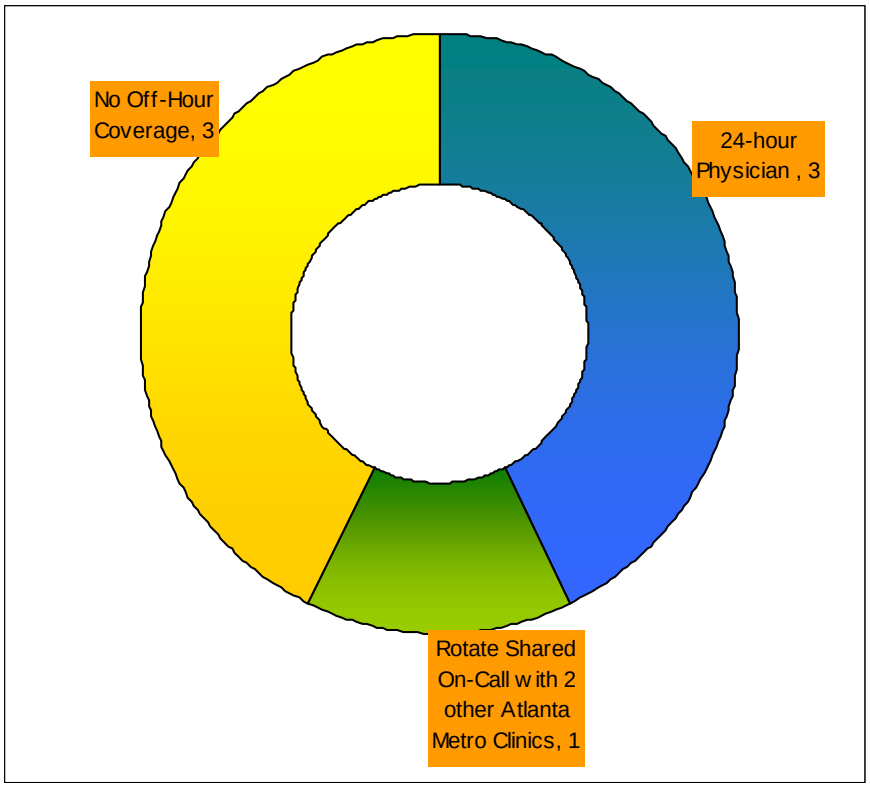
As part of the safety net patchwork, each facility has its own goals and objectives in providing specific resources. All seven facilities work on a first come first serve basis when accepting new patients. Graph 7 displays each participant's hours-of-operation.

Graph 7. Accessibility of Providers



The Community Health Clinics were open 30 hours a week on average, while the three emergency rooms operated 24 hours a day, 7 days a week. If the organization is closed, the question remains on how their patients would gain access to their physicians, medical records, or seek treatment for minor issues in the emergency room. Physician coverage is presented in Graph 8.

Graph 8. Physician Coverage



Accountability of Quality Care

Since uninsured patients have limited points of entry to primary medical care, it is important to gain knowledge of the quality of care being provided. It is great to note that all seven of the safety net facilities are evaluated by at least one national organization to provide accountability. The three hospitals shown were all evaluated by the Joint Commission for the Accreditation of Healthcare Organization (JCAHO). The two organizations managed by Wellstar Health System, Kennestone Hospital's Emergency Room and Cobb Hospital Emergency's room were also evaluated by Health Grades and the Institute of Health Care Improvement. Cobb and Douglas Public Health Department in Cobb County is evaluated by their executive director of the greater Cobb and Douglas

Public Health. This includes a great deal of reporting to the state and federal Department of Health and Human Services for financials as well as health outcomes. The respondent for the Good Samaritan Health Center of Cobb explained that several private foundations conducted site visits and reviews before and after the grants are made. These may not always be the same foundation but they have had two or more every year since opening. Good Samaritan Health Center of Cobb is evaluated on its financial records by the Evangelical Council for Financial Accountability (ECFA) and its health outcomes are evaluated by Practice Partner Research Network, managed by the University of South Carolina Medical College. The Luke's Place and Cobb Health Partners had the least amount of documentation or award recognition, in part because of its very limited operating hours and business models that run under separate 501(c)3s. Cobb Health Partners has its financial records evaluated under its parent organization, the MUST Ministries.

Conclusion

As the researcher reviewed the results, there are several key relationships that stand out. First, the accessibility of providers and limited hours of operations compared to the number of uninsured residents in Cobb County is very small. This means an excessive number of patients are forced to visit the emergency room departments, even for minor conditions. Even phone access to a primary care provider is only attainable at one of the community health clinics.

Second, the lack of tracking primary language along with unanimous reports on interpreting needs is a significant finding. The U.S. Census Bureau's American

Community Survey estimates that Cobb County has 114,280 persons (age 5 and older) who speak a language other than English. The 2005-2007 American Community Survey also estimates that 22,626 Latinos did not consider themselves Mexican, Puerto Rican or Cuban. Chief executive officers and executive directors report that the second most common interpretation needs is for Portuguese speaking patients. An increase in Central- and Southern American residents may have resulted in this increase. Seeing the trend across organizational lines can help Community Health Centers (CHCs), emergency departments, and all healthcare providers plan for the future needs.

Third, the outreach services provided showed that 71 percent of the participants had a Drug and Alcohol Program. Perhaps these programs emerged from federal requirements, and physicians seeing a need, or from increased diagnosis of disease. Further study on the goals, participation, and outcomes of these programs would be advantageous. Additionally, 86 percent of the participants provided optional spiritual support to their patients. The executive directors expressed the benefit of these varying programs to their patients. An in-depth analysis of these programs would also be valuable to health leaders.

Recent conversations for complete overhauls of the United States healthcare system have included giving the government more control on regulations and creating an insurance plan that gives people a choice of coverage types, providers, and is based on the market. Utilizing supply and demand still seems to be the best way to provide affordable and adequate coverage. Realizing that projected costs of these plans use extreme guesses, the federal government desperately needs to bring the safety net community into discussions and policy decisions. CHCs' expansions could significantly

increase the number of uninsured persons with access to safety net providers. Regular access to primary care through CHCs encourages uninsured patients to seek care for symptoms on a timely basis when they can be treated in an outpatient setting for milder symptoms rather than requiring expensive hospital resources. One particular study:

> strongly suggest[s] that increased availability of CHCs to more uninsured people will increase their access to medical care, specifically in terms of more uninsured having a usual source of care, fewer having unmet medical needs, and more having any ambulatory or general medical visits. The results also suggest that greater availability of CHCs may reduce the uninsured's use of costly hospital services by reducing the probabilities of emergency department use and of inpatient hospital stays (Hadley and Cunningham, 2004, 1533).

Specifically, Community Health Centers that have been providing for the uninsured have become experts in creating mini-systems through counties like Cobb County, Georgia. In Cobb County, the leaders of uninsured care have working knowledge both about systems that work and the gaps that still exist. Their continued participation to discuss and build relations between one another will aid the community with increased efficiency, quality care, and healthcare in tomorrow's world.

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Appendices

Appendix A

COVER LETTER

Research project title: Safety Net System: A Case Study of Primary and Specialty Care for Uninsured Residents in Cobb County, Georgia
Investigator's name: Kacie Dougherty
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1000 Chastain Rd
Master of Public Administration Program
Political Science and International Affairs
Mail Stop #2205
Telephone number where researcher can be contacted:
404-783-2533 or KacieDougherty612@hotmail.com

Dear Participants,

The purpose of this study is to analyze data from a survey of Cobb County safety net facilities to determine primary and specialty care accessibility for low-income patients as evidenced by the availability of resources, affordability of services, accountability of quality care, and policies for the uninsured

The researcher will interview of administrative staff of safety net care sites in Cobb County, Georgia that are sponsored by hospitals, community health centers, or public agencies. These agencies typically serve low-income populations. Private physicians' offices and clinics that provide only a narrow range of services (e.g., immunizations) are excluded from the analysis conducted for this study. Only sites that provide comprehensive primary care services or serve as a specialist care referral for those sites will be included.

Participants are asked to meet with the researcher and answer questions on a broad range of items about institutional policies and practices, patient population, and visit volume. Questions about visit volume and specific policies or practices refer to the 2008 calendar year. A battery of questions are designed to ask about uninsured patient registration policies (whether uninsured are accepted, sliding fee schedules, and fee collection policies).

Agencies are also asked whether they provide selected "wrap-around" services and, if so, whether the services are formally staffed or provided informally by volunteers. Questions are included about the degree to which sites have managed care contracts and serve managed care patients, and a battery of questions addresses practices that are typically preferred or required by managed care organizations to provide certain services physician admission privilege, automated data systems, evening and weekend hours, after-hours physician questions characterize each site's patient population focuses on the qualifying income level for the patient or patient's family, percentage of patients who are unemployed, patients who did not speak English, and the range of preferred languages. In addition, visit volume by payer and managed care enrollment were used to characterize each site's patient mix.

Questioning should last within 30 minutes, and all follow-up questions will be conducted via phone or e-mail, and will be completed by December 15, 2009. The research will provide an update, information, and an analysis of the safety net system in Cobb County. It will also connect health leaders in hopes of building strategic relationships to strengthen Cobb County's safety net system.

The purpose of this research has been explained and your participation is voluntary. You have the right to stop participation at any time without penalty. You understand that the research has no known risks, and you will not be identified. By completing this survey, you are agreeing to participate in this research project.

THIS PAGE MAY BE REMOVED AND KEPT BY EACH PARTICIPANT

Research at Kennesaw State University that involves human participants is carried out under the oversight of an Institutional Review Board. Questions or problems regarding these activities should be addressed to Dr. Ginny Q. Zhan, Chairperson of the Institutional Review Board, Kennesaw State University, 1000 Chastain Road, #2202, Kennesaw, GA 30144-5591, (770) 423-6679.

Appendix B
Questionnaire

1. Do you have income level restrictions for the patients you see?

1. Yes 2. No

If yes what are they?

1. 200% or below federal poverty level

2.100% or below

3. No restrictions

4. Other _____

2. Do you accept uninsured patients?

1. Yes 2. No

3. Do patients pay a sliding scale fee?

1. Yes 2. No

4. Explain your fee collection policies.

_____

_____

5. Do you provide translation services?

1. Yes 2. No

6. If you answered yes to number 5, please answer question 6 and 7. If you answered no, please skip to questions 8. Please rank in order from 1-6, with 1 being the least amount of patients who need translation in this language and 6 being the greatest number of patients in the language you need translating for.

1. Spanish
2. Portuguese
3. French
4. Italian
5. Mandarin Chinese
6. Other_____

7. Are translation services provided by staff?

1. Yes 2. No

8. Do you accept Medicare?

1. Yes 2. No

9. Do you accept Medicaid?

1. Yes 2. No

10. Do you have a Medicaid eligibility plan?

1. Yes 2. No

11. Do you have a case manager?

1. Yes 2. No

12. Do you provide specialty referral services?

1. Yes 2. No

13. If you answered yes to number 12 please answer number 13. If you answered no to number 12, please skip to question 14. How do patients pay for specialty referral services?

1. Sliding scale as this program
2. Specialty program has own sliding scale
3. Patient pays entire cost of services
4. I don't know

14. Do you provide transportation services to your clinic or referrals?

1. Yes 2. No

15. Which of the following outreach services or social programs do you provide? (You may mark more than one answer.)

1. Mental health
2. Drug and alcohol
3. Grief counseling
4. Spiritual support
5. Child care
6. I don't know

16. Which managed care contracts do you work with?

1. Managed Care Organizations
2. Health Maintenance Organization
3. Preferred Provider Organization
4. Other_____

17. How many managed care contracts did you receive last year (2008)?

_____

18. How many Medicare patients are you required to see each year?

1._____
2. We are not required
3. I don't know

19. How many Medicaid patients are you required to see each year?

1. _____
2. We are not required
3. I don't know

20. Do you have automated data systems?

1. Yes 2. No

21. What are your hours of operation?

1. 24 hours
2. Monday though Friday and some weekend hours
3. Monday though Friday and some evening hours
4. Monday though Friday and selected weekend or evening hours
5. Monday through Friday only
6. Weekend or Evening Hours only
7. Other_____

22. What kind of physician coverage do you have after hours?

_____

23. How many patients did you serve in the last fiscal year that did not speak English?

_____

24. How many Medicare patients did you serve in 2008?

_____

25. How many Medicaid patients did you serve in 2008?

_____

26. Do you have an outside evaluator on medical outcomes?

1. Yes 2. No

27. Please list any outside evaluators your agency reports too.

_____

_____

_____